# Alcohol and healthy ageing

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# Alcohol and healthy ageing: a challenge for alcohol policy


## Abstract

Objectives: This paper presents findings of a qualitative study of older people's use of alcohol during the retirement phase of life and identifies ways that an improved understanding of older people's drinking can inform policy approaches to alcohol and to active and healthy ageing.

Study design: qualitative semi-structured interviews conducted with a self-selecting sample of retired people.

Methods: participants were recruited from three geographical locations in the West of Scotland. A quota sampling design was used to ensure a broad spread of participants in terms of socioeconomic position, age and gender. In total 40 participants were interviewed and the data analysed thematically using Braun and Clarke's (2006) approach[1].

Results: Amongst those who used alcohol, it was most often framed in terms of pleasure, relaxation, socialising and as a way to mark the passage of time. It was often an element of social occasions and interactions both in private and in public spaces. There were also many examples of the use of imposed routines to limit alcohol use and of a decreasing volume of alcohol being consumed as participants aged. This suggests that older people are often active in constructing what they regard as 'healthier' routines around alcohol use. However, processes and circumstances associated with ageing can lead to risk of social isolation and/or increased alcohol consumption. These include retirement from paid work itself and other 'biographical disruptions' such as caring for a partner, bereavement and/or loss of social networks.

Conclusions: These findings highlight processes which can result in changes in drinking habits and routines. Whilst these processes can be associated with a reduction or cessation of alcohol use as people age, they can also be associated with increased risk of harmful alcohol consumption. However, fractured or disrupted routines, particularly those associated with bereavement or the burden of caring responsibilities, through increasing the risk of loneliness and isolation, can construct increased risk of harmful alcohol consumption. These findings reframe the pathway of risk between ageing and alcohol related harm by highlighting the vulnerability to harmful drinking practices brought by fracture or sudden change of routine. The findings point to a role for public health in supporting the reconstruction of routines which provide structure and meaning and can be used to actively manage the benefits and harms associated with drinking.



## Keywords

Alcohol; ageing; retirement; policy


## Introduction

Current public health policy related to older people's drinking emphasises increased and unique risks associated with alcohol consumption in later life[2,3,4]. However, there is also a growing emphasis on encouraging older people to lead active and connected lives in order to promote healthy ageing[5,6] and the drinking of alcohol is closely associated with socialising and leisure[7,8].

Older people's drinking is generally characterised as exhibiting a 'spread' pattern (regular consumption of small amounts) as opposed to younger people's 'binge' or more concentrated style of drinking[9] and non-drinking is more common amongst older age groups[10]. Generally, therefore, older people's alcohol consumption has been regarded as less of a public health priority than younger people's drinking.

There are, however, clear signs that this perception is changing[11]: evidence suggests that the present generation of older people drink more than previous generations[12] [13] [14]. Although alcohol consumption usually declines with age, it has been argued that wider social and cultural changes, such as an increasing amount of disposable income for many older people, improved morbidity, and increased leisure time, have facilitated an increase in drinking compared to previous generations[15].

In terms of current thinking in public health, the biological, psychological and social changes associated with ageing has led to older people being described as 'uniquely' vulnerable to alcohol[16]. Potential risks for older people include, for example, exacerbating existing conditions, interactions with other medications, falls, confusion, memory loss, self neglect and accidents[17] [18] [19] [20]. Although alcohol dependence is comparatively low amongst older people, alcohol issues in the older population have been described as neglected and 'hidden'[21] [22] [23] [24] [25] [26] [27] [28].

The Big Lottery funded 'Drink Wise, Age Well' programme was launched recently in the UK with the aim of reducing alcohol related harm amongst older people – their initial report stresses a 'pressing need for action to reduce alcohol-related harm in older adults across the UK'[29]. This framing of older people's drinking as a 'silent epidemic'[30], characterises a shift in public health discourses around older people's drinking and clearly signals a risk based approach to an emerging public health problem.

## Healthy ageing

Tackling social isolation (the absence of contact with others) and loneliness (the subjective experience of isolation regardless of choice) have recently emerged as central tenets of new policy approaches to improving health outcomes for older people. Research has linked social isolation and loneliness to depression and higher rates of mortality[31] and reduction in rates of social isolation have been framed as policy targets for improving the health and wellbeing of older people. This is especially evident in *All Our Futures: Planning for Scotland with an Ageing Population*[32] in which the then Scottish Executive set out its policy response to the challenges of an ageing population. In so doing, extensive use was made of the World Health Organisation (WHO's) 2002 conceptualisation of 'active ageing'[33], defined as the process of maximising older people's opportunities for health, participation and security to enhance quality of life.

Within this context, the cultural positioning of alcohol as uniquely facilitative of socialising, friendship and bonding[34] [35] becomes relevant. Studies such as those by Wilson et al. (2013)[36] and Ward et al. (2008; 2011)[37] highlight the perceived benefits of sociability and relaxation associated with consuming alcohol. Wilson et al. (2013) for example, stress the role that drinking can play in preventing older people from "losing touch" with their social networks[38]. Research also suggests a range of health benefits of moderate alcohol consumption for older people, such as on mortality and a range of psychological benefits, which may be linked to reduced stress and greater sociability[39]. Compared with non-drinkers, older (moderate) drinkers have been found to score

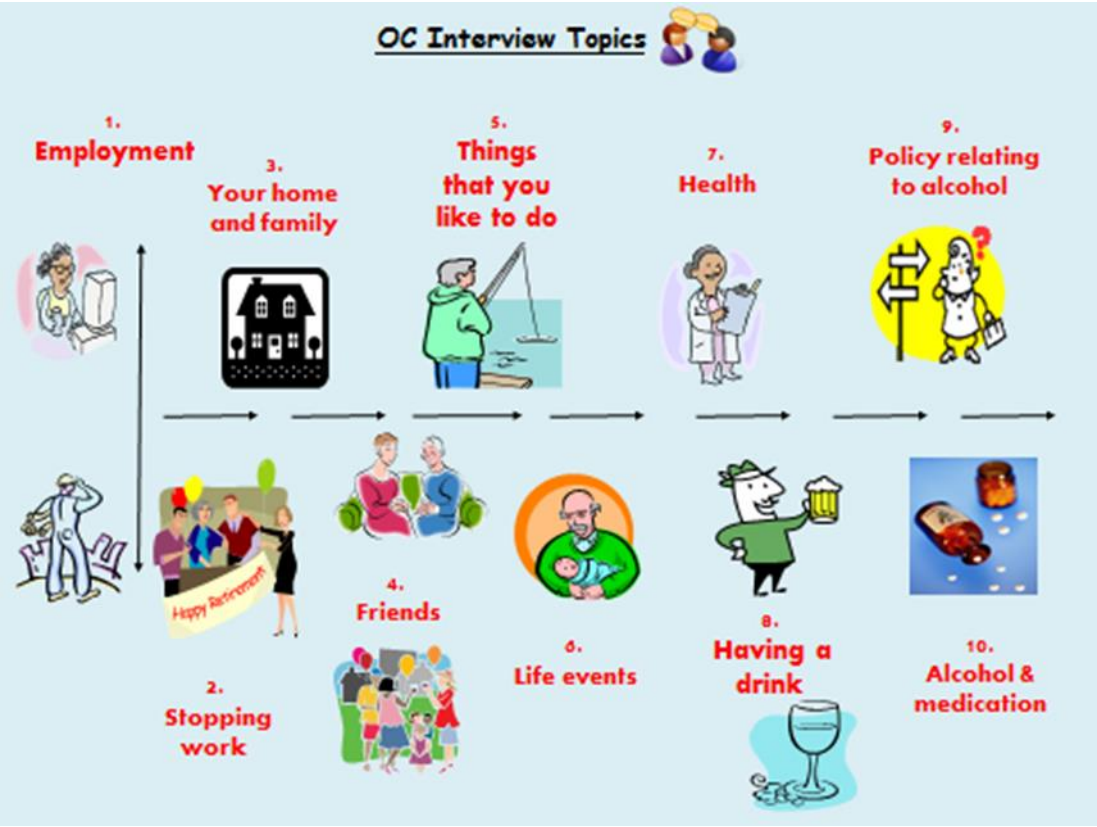
higher on cognition, verbal memory, and physical health, and lower on depression [40] , have fewer falls and greater mobility[41].

This lies in stark contrast to the more risk and harm approach which is beginning to dominate the study of older people's drinking and it is this tension which provides the background context to how older people use and view alcohol.

## Methods

Data was collected via semi-structured qualitative interviewing of 40 retired men and women, carried out by one of the authors (FM) between August 2014 and June 2015. The meaning and uses of alcohol were explored in three age cohorts: 'younger' retirees aged 55-59 years (n = 10), 'middle' retirees aged 65-69 years (n = 16) and 'older' retirees aged 75-79 years (n = 14). A quota sampling framework was designed to gain a diverse sample in terms of gender (23 females and 17 males) and socio-economic status. For the latter, The Scottish Index of Multiple Deprivation (SIMD) was used as an area based measure of deprivation where decile 1 refers to areas categorised as 'most deprived' and decile 10 refers to areas regarded as 'least deprived'[42]. The sample comprised 21 participants who lived in areas categorised as 'more deprived' (i.e. deciles 1-5) and 19 in 'less deprived' areas (i.e. deciles 6-10).

Interviews were conducted on a one-to-one basis. The majority took place at the participant's home and a small number in a private room at the University/GCPH. A visual topic guide was used covering a variety of topics including stopping work, home and family, friends and life events as well as health, having a drink and awareness of alcohol policies (see Figure 1). This guide was placed with participants, and the interviewer asked open questions related to each topic.



(Figure 1: Older cohort interview topic guide)

Participants were initially recruited through the Scottish Primary Care Research Network (SPCRN). The SPCRN recruited four general practitioner (GP) practices that agreed to grant access to their patient databases which were then searched to identify patients fitting the selected age bands. These lists were then screened by GPs to exclude anyone they believed should not be sent an invitation. This included, for example, recent cancer diagnosis, those undergoing palliative care or who had suffered a recent bereavement, mental health or addiction issues, housebound, learning difficulties and stage 4/5 kidney disease. Invitations were then sent to a random sample of patients remaining on the list. In total, 280 invitations were sent and reminder letters were sent to non-responders. This led to 25 interviews. Invitations consisted of a cover letter, participant information sheet, and a response slip with a pre-paid envelope. Recipients were asked to return the slip to indicate whether they were interested in taking part. The researcher then phoned participants to discuss further and arrange the interview if they were happy to proceed. The researcher's contact details (telephone and email) were also provided so that recipients could contact the researcher directly to register their interest if they wished.

A second wave of recruitment extended the sample size using local community groups and organisations to issue invitations via their newsletters and meetings. This led to a further 15 interviews. Informed consent was gained via a signed consent form and the provision of a participant information sheet, and participants were given £15 high street vouchers in recognition of their time. Full ethical approval was granted by the University of the West of Scotland Research Ethics Committee and West of Scotland Research Ethics Service - West of Scotland REC3 (Greater Glasgow and Clyde).

The interviews were audio-recorded and transcribed with the participant's permission. Thematic data analysis was conducted following Braun and Clarke's (2006) approach[43]. QSR nVivo was used to manage the coding process, allowing the codes to be applied systematically to the transcripts and refined throughout the process. Early transcripts were analysed separately by two of the research team and comparison of notes from these transcripts produced initial codes which were then refined as data analysis proceeded. Simultaneously, short biographies were written for each respondent which were used in conjunction with the data extracted from nVivo.

## Results

The majority of participants were current drinkers (34/40) and this section focuses on their accounts to provide an insight into results relating to routines. For current drinkers in our sample, drinking was framed ambivalently: pleasure, sociability and relaxation were key associations but alcohol was also framed in ways that suggest its use as a coping mechanism to support wellbeing:

> "I feel that it's much better than pills and some people that don't take a drink, sometimes you think it would do them the world of good to take a drink" (OCA307 – older cohort, female, SIMD 2).

It was also evident that alcohol use was highly ritualised. Whether social or solitary, drinking was largely embedded into the everyday rituals and routines of the participants' lives. For example:

> "I drink two drinks every day before my dinner. I just think it's an appetizer, just gives you that wee boost for eating your dinner, aye" (OC118 – older cohort, male, SIMD 4).

For many in the sample, these routines were continuations of their drinking patterns from earlier in their lives when they were built around work, family and other midlife commitments and pursuits. Nevertheless, change and adaptation of drinking routines associated with ageing and with the retirement phase of life were evident amongst many in the sample.

### Changing routines associated with getting older

Amongst participants who drank alcohol, many mentioned a shift towards drinking at home. This was often framed in terms of greater convenience and lower cost, as well as the potential to drink more:

> "We probably drink more at home because you don't have to think about going home, you are home and it's quite easy to, uh huh, have another one or finish the bottle if you wanted" (OC088 – middle cohort, female, SIMD 10).

However, although many participants reported an increase in home drinking as they got older, drinking in social environments was also evident and for some (mainly male) participants, was the only environment in which they consumed alcohol. Once again, this was characterised by daily or weekly routines and rituals. A key part of the experience was the opportunity for social interaction: this was when they would 'see familiar faces' and enjoy the company of others.

Amongst women, regular 'nights in' with friends was more common but similar themes of sharing the company of others and conviviality were evident.

> "So we get together and we just love our wine appreciation and we chat, sometimes we laugh, sometimes we cry…" (OC088 – middle cohort, female, SIMD 10).

Overall, normal drinking styles were often embedded into daily, weekly and occasionally monthly routines. There was an identifiable regularity and set pattern to what, when, where and with whom they drank alcohol. Whilst there were variations in this – special occasions and holidays were frequently discussed as times when more alcohol would be drunk or drinking would be more frequent - in general, normative drinking was woven into the routines of people's lives. Furthermore, whether drinking took place in company or alone, in private or in public spaces, drinking alcohol was often constructed as a mainly positive experience.

Some participants had adapted their alcohol routines in retirement in response to what they viewed as the 'dangerous' or 'negative' consequences of drinking. Whilst some of the identified negative consequences were not age specific (such as weight gain, general health, avoidance of hangovers and avoidance of being drunk) others were specifically linked with getting older, particularly changing tolerance for alcohol:

> "Nowadays my tolerance level is probably about a pint and a half of beer or two malt whiskies. Any more than that and I'm not going to sleep well and I'm going to feel an energy crash about eleven o'clock the next morning" (OCA306 – male, middle cohort, SIMD 3).

In light of these consequences, some participants stopped drinking altogether, whilst others adapted by consciously moderating their consumption.

> "So I said right, so I don't drink during the week and at the weekend I, if I'm here, I do not drink before ten o'clock at night and then I only have three, I only drink whisky really (in the house)" (OC190 – older cohort, male, SIMD 9).

This suggests that older people are often mindful of the negative aspects of alcohol and take conscious steps to limit their intake. Whilst this is not always constructed in health terms directly, the consequences of drinking too much are acknowledged and taken into account in the adaptation of drinking routines.

Where participants talked about changes in their drinking that they felt were more negative, this was regularly connected with wider changes and life events such as caring for a dependant partner or relative, for example, or loss of mobility or bereavement. However, as significant as the emotional or psychological aspects of such changes are, what was also evident was the significance of broken or disrupted routines in increasing the risk of dependant drinking.

> "I mean 24 hours wasn't enough when my hubby was here and all of a sudden, although that's no excuse, but all of a sudden you've got this time on your hands and you're thinking, "what am I getting up out my bed for", you know?" (OC089 – middle cohort, female, SIMD 2).

Nevertheless, similar disruptions and/or enforced changes to routine could have the opposite effect in that they could be the catalyst for a decline in the use of alcohol, or cessation.

> "I wouldn't be sufficiently able to cope [in caring for my dependant husband]. It's a, you know it's really quite a demanding job" (OC143 – older cohort, female, SIMD 7).

Therefore, it is worth emphasising that changes in drinking routines during retirement, whether in terms of increase or decline in amount or changes in the where, what, when, and with whom, were often the consequence of other changes in everyday routines.

## Discussion

The findings from this study suggest that drinking amongst retired people is not inherently at odds with 'active' and 'healthy' ageing. The emphasis placed on social connectedness in particular suggests that socialising with others, at home or in public spaces, on a routine or regular basis is a significant feature of healthy ageing. Similarly, the enjoyment of periods of leisure time – alone or with others – has also been linked to healthy ageing. Our findings indicate that alcohol is used by older people in a variety of ways that are directly associated with social engagement and relaxation, and thus with mental and physical wellbeing.

In this context, the risk approach to alcohol use in older people, which has begun to dominate public health policy, creates a tension with policies aimed at healthy and active ageing. Both policy approaches begin with the same central 'problem' – the costs and challenges of an ageing population. However, we would argue that the asset-based approach to healthy ageing and its explicit foregrounding of older people as active and empowered in the shaping of their future health conveys a more positive message about older people's health. Therefore, we would suggest that

alcohol need not be viewed simply as a hurdle to health and wellbeing without attending to the context in which the drinking is situated. It is important to understand what people are seeking when drinking in social contexts and to ensure that opportunities to socialise, connect and make friends are available that do not centre on alcohol. This is particularly important given that disrupted routine and the need to adapt to change could be risk factors for increased alcohol consumption in later life. Furthermore, the strategies employed by older people to curb their drinking is something that should be promoted and encouraged in public health messages as a way of reducing overall alcohol use, without stigmatising older people's drinking.

However, alcohol consumption could have the potential to be harmful when it becomes the primary means by which people stay connected to networks of friendship and support in retirement. This is highlighted by alcohol being referred to within contexts of sociability by some in our sample but in close proximity to reported strategies to manage intake. This indicates that wellbeing and risk are closely associated in understandings of drinking, the conscious routinization of consumption being developed to manage associated risks. It should be noted here that this sample excluded those with an identified addiction to alcohol. Therefore, this management of risk may not apply to those with addiction issues in the same way as it did for this sample.

In terms of health professionals working with older people, we would recommend that consideration is given as to whether the risk factor of fractured routine and the attendant risk of loneliness applies, rather than focusing on alcohol use alone. Where this applies, we would recommend that social prescribing and linking patients to opportunities for meeting others in the community should be combined with advice to moderate alcohol intake. This would provide support in reconstructing routines and could be used to actively manage the benefits and harms associated with drinking.

In conclusion, we would suggest that constructing alcohol use amongst older people as inherently more risky or problematic negates the wide variety of experiences and routines that exist amongst older people and risks stigmatising older people's drinking in a way which may have detrimental consequences to their health if it results in the limiting of their activities and interactions. Recognising alcohol consumption as located within strategies to maintain supportive contact and as featuring conscious decisions to manage risk would allow for a more holistic understanding of older people's agency in creating and maintaining an experience of positive ageing. This would help practitioners and service providers re-locate the locus of risk from the presence of alcohol itself to the harm creating processes of disrupted routines and the associated disruption of networks stemming from exiting paid employment, increased caring responsibilities and declining physical health. Action to support older people negotiate the risks of alcohol in later life should look to support the achievement of social connection in disrupted circumstances alongside a focus on the amount and frequency of alcohol consumed.

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